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ABSTRACT

Noting that approximately one third of the medical internships and residencies in the United States are filled by foreign medical graduates (FMGs), this paper argues that institutions where FMGs are administering care have failed to deal with the communication gaps created by language deficiencies and cultural barriers. The paper identifies specific problems facing the FMGs and describes teaching methods used for improving their communication skills. It concludes with recommendations for ways communication experts and medical professionals can cooperate in offering communication expertise to the FMGs. (FL)

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FOREIGN MEDICAL GRADUATES:

Identification of Specific Problems and Methods for Improving Their Communication Skills

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Imagine yourself in the situation of a patient being examined by a foreign resident physician who has a very limited knowledge of your language. You might be at one of the leading cardiac clinics in the United States relating your medical and biographical history to the physician prior to an angiogram, a test patients anticipate with a high level of anxiety. The physician asks, "Is your father living?" and you respond, "He died in 1940." Again the physician asks, "Is your father living?" and you repeat the same answer. Still not comprehending your reply, he asks the same question a third time. In utter frustration you suggest angrily that he go on to the next question. Or imagine that you have just been taken into the emergency room after a fall on the ice which has caused severe injury to your shoulder and back. Your history and x-rays have been taken. After a long wait a foreign physician enters the examining room, begins to poke you in the abdominal area and asks if you have a "pen." With some consternation as to why he needs a pen, you say, "Yes, I think I have one in my coat pocket." Since this answer does not bring the desired reaction, you ponder the possible meaning of his question before the moment of illumination when you realize he wasn't asking about a "pen," but a "pain."

These two situations, which are actual cases, illustrate a communication problem that exists in hospitals and health-related fields not only in the United States but in many parts of the world wherever there is an exchange of foreign medical students or graduates. This communication problem presents the physician and the patient with a frustrating

situation akin to the screaming ill baby who cannot identify the source of his discomfort. The language problem of the patient and foreign physician is further compounded by the wide gap in perceptions and traditions characteristic of cultural differences.

At best, the possibilities for intercultural communication breakdown are tremendous in a medical setting. The technical jargon, the patient's lack of knowledge of anatomy and physiology as well as his feeling of inadequacy in explaining his symptoms, his anxiety concerning the nature of his illness and the attitudes which both the patient and physician have toward one another provide many stumbling blocks in constructing meanings that will enable the physician to function in a satisfying way. To complicate the matter further in the therapeutic relationship defenses are provoked by the expectation of criticism or of appearing "ridiculous" as in the case of the physician who must have felt some loss of face when his attempt to say "pain" was misunderstood for "pen." As Carl Rogers has suggested, a major barrier in a helping relationship is our very natural tendency to judge, to evaluate, even in our own feelings, what the other person does.[1] With this undercurrent of censure, there is a tendency to judge the other person as incompetent. And in such a situation the trust and empathy so important in the doctor-patient relationship are not easily established.

What is the extent of this communication problem in the United States medical profession? In 1977-78, we had 60,561 residents and interns in the United States. One-third of these were foreign medical graduates; the greatest number come from Asian and Pacific countries

with India, Philippines and South Korea among the top four countries.[2] According to the 1978 Scherr report, in New York alone one-half of the 5,500 resident physicians who provide health care are foreign medical graduates.[3] Stevens and Vermeulen reported that, in 1970, almost 78% of the hospital residents in New Jersey were foreign medical graduates; Delaware had 66%; and Rhode Island had 60%.[4] As to the number of students who are coming to study medicine in medical schools in the United States, in the year 1977-78, there were 88 students from Canada and 732 from other countries.[5]

There are no accurate current figures on the number of Americans who are studying outside the United States and Canada but the number is increasing. McGuinnes reported that he found the total number of Americans studying abroad in 1970 to be in the range of 3,500 to 4,000 who, for the most part, attended 22 medical schools.[6] Except for the Philippines, non-English speaking countries do not provide English speaking medical schools. Therefore, Americans and Canadians who get their training abroad encounter language and communication difficulties although, according to Marien's Guide to Foreign Medical Schools, language courses are readily available and relatively inexpensive.[7] At the same time, the foreign physicians coming to the U.S. who have not been trained in English or whose cultures are very dissimilar are at a distinct disadvantage. Haug and Martin reported that only 7.6% of the total foreign medical graduate population in the U.S. came from foreign countries in which English is the predominant language.[8] Their inability to speak fluent English is the most frequent criticism made of them.[9]

Problems of discrimination because of what may be considered to be inferior training or abilities are encountered by foreign medical students wherever they go. Our students going to other countries find that professors are not only unavailable, but they appear to have some hostility toward them. One physician reported that because he could not get into an American school, he had trained in a Swiss school where he felt discrimination. He experienced discrimination again when he returned to the U.S. and could not get the kind of internship he wanted because of his foreign training.[10] Foreign medical students and graduates coming to the U.S. also meet with the attitudes that they are somewhat inferior. It is acknowledged that these attitudes result in the condescending treatment toward foreign medical graduates as well as their own self-perception of being second-rate. This becomes a self-fulfilling prophecy in relation to the way in which they are treated by their peers, staff members and teachers. For all foreign medical graduates and medical students there is cultural shock.[11] Much of this is no doubt attributable to language difficulties.

Communication barriers apply to all foreign medical students and graduates but I would like to address the particular problem of the graduate residents and interns, or FMGs, the group with whom I have had experience. In outlining the problem I will relate it to the concerns of communication educators and explain my approaches to working with FMGs. What applies to this group, I believe, will be applicable to most FMGs as well as foreign medical students in any country.

Because laws have facilitated their staying here after training, many FMGs have not returned to their home countries. Also, some fields of specialtv (anesthesiology, pathology and physical medicine) have limited appeal for American physicians and are being filled by foreign physicians. Furthermore, many FMGs can no longer fit into their own countries either culturally or professionally so they have remained in the U.S.[12] In recent years almost half of the newly licensed physicians have been products of foreign medical schools.[13] According to Stevens and Vermeulen, it has been largely an unplanned and unregulated training situation into which FMGs have been injected.[14]

As far as the future is concerned, the problem of incoming FMGs with severe language deficiencies will be alleviated by the recently adopted Qualifying Visa Examinations and new legislation which sets stringent requirements for language proficiency. The first QVE was given in September, 1977, so it is really too soon to judge the effects of this examination. However, even though the rate of increase of total house-staff positions is declining because of these more stringent requirements, there appears to be nearly 20,000 positions filled by FMGs, many of whom were not admitted under the QVE.[15] This means that a large number of foreign medical graduates who are completing their training and many who have taken up residency in the United States still have language deficiencies. There still exists between patient and FMG, between FMG and staff, great possibilities for communication breakdown.

What are the consequences of these language deficiencies? First of all, the handicap in language hinders adjustment to American methods.[16] It has been suggested that FMGs continue to perform less well than their

American counterparts even after several years of graduate training in terms of their professional ability.[17] Dasco, Angler and Rush pointed out that "performance and accomplishments of the FMG are proportional to both his adaptation to life in the United States and his fluency in the English language."[18] Margulies et al., in their study of the professional qualities of FMGs observed that an inadequate command of English affected every aspect of the FMGs' work.[19] Butter also reported that language deficiencies have a direct effect on the quality of care.[20] These claims have been refuted by Mick[21] and, in a more recent study, by Saywell et al. who measured the quality of care of FMG attending physicians and found that the most consistent differences in performance were associated with hospital rather than physician characteristics.[22] Most studies do, however, acknowledge language problems and cultural shock. Interestingly, surgical residents have been an exception to the charge of lesser competence. In the Halberstam, Rusk and Taylor study surgical residents were rated by supervisors as approximately equal to U.S. graduates in terms of overall performance.[23] A reason for the lack of significant difference was somewhat facetiously offered by Derbyshire in his book on licensure when he suggested that surgeons can do their jobs without the need to speak English.[24] It could be that, in surgery, there is less dependence upon the doctor-patient relationship and the ability to speak English than in, for example, psychiatry or internal medicine. However, Bird asserts that "of all the technical aids which increase the doctor's power of observation, none come even close in value to the skillful use of spoken words--the words of the doctor and the words of the patient."[25]

Despite this acknowledgment there are few programs for orienting foreign trained physicians to the American medical care system before employment in it, yet, Stevens and Vermeulen maintain that the hospitals have a "de facto responsibility" to give or arrange language training.[26] A survey of hospitals in the late 1960s found at least one-half of the 7,000 FMGs in the Philadelphia area would have benefitted from language training but most were not getting it.[27]

Two specific programs have been cited in journals: the pathology staff in a Jacksonville, Florida hospital developed a system of close individual supervision in language training;[28] three separate approaches were arranged cooperatively by the Philadelphia County Medical Society, The Center for International Visitors and the Board of Education. Courses in English were taught by volunteers on a one-to-one basis and medical terminology classes were conducted by physicians. Programs for assisting the foreign physicians' wives with their linguistic skills were also arranged.[29] The third program was initiated in Cincinnati at the Mayfield Neurological Institute by speech professor Mary Caldwell about 10 years ago. I worked in this program for four years with FMGs who were specializing in neurosurgery or who were on rotation.

Should this communication problem of Foreign Medical Graduates be the concern of communication educators? Clearly here is an area where someone should take more responsibility for improving a situation which is frustrating, often humiliating, sometimes humorous and may be, literally, a matter of life and death. Barnlund suggests that probably at least "six people" are involved in a communication: "The person you

think yourself to be; the man your partner thinks you are; the person you believe your partner thinks you are; plus the three equivalent 'persons' at the other end of the circuit."[30] Reducing the uncertainties in that transaction, Barnlund maintains, is the aim of communication.[31] To engage in mutual exchange and understanding in cross-cultural contexts Hall says that we need to be able to read and interpret correctly the adumbrations or feedback mechanisms which are so often misunderstood.[32] Indeed, communication needs of FMGs are in the province of communication experts and include intercultural and interpersonal skills, semantics, linguistics and speech production.

Admittedly, there are good reasons why we have gained limited entrance into this field. It is a sensitive professional area with a hierarchial structure which makes entry difficult. Barnlund has identified some of the problems and has found physicians amenable to the idea of improvement.[33] However, there has been little follow through, for in addition to the professional sensitivity and hierarchial structure, are the exigencies of time and money. Interns and residents are given little or no time upon their arrival at the appointed hospital for orientation. On the job, they work long hours and are subject to being on call every other night or every third night for emergencies and surgery. This means that regular attendance at scheduled classes is nearly impossible. Any instruction must be given to very tired FMGs under less than ideal circumstances with frequent interruptions and absenteeism. Finally, there is the financial reason. Many FMGs do not feel that they

can afford private lessons, and the hospitals seem reluctant to provide the services for them.

Despite these problems, the need still exists and even some assistance is better than none. We, as communication educators, do have an opportunity, if not a responsibility, to offer services which will further international health and understanding.

Now, I would like to explain how I identified and met some of the specific communication needs of the FMGs with whom I worked. Since they came from widely different cultures, there was great disparity in language proficiency. FMGs in our program came from Thailand, Japan, Korea, Iran, India, Puerto Rico, Spain and France with the majority from the Pacific areas and Asia. Because they worked closely in the hospital setting, they soon learned to communicate with one another on the technical level fairly well. However, members of the staff, particularly nurses and telephone operators, complained of difficulty in understanding them. These complaints were relayed to me through the secretary or by the FMGs themselves who admitted that communication with patients was also a major problem for them. Through questioning and role playing, I was able to identify some of their specific difficulties with patients. In our area we have a considerable mix of regional speech which is difficult enough for us to understand, so you can imagine an FMG's problem! In addition to patient interviews, FMGs had to be able to present patient cases at weekly meetings before the senior physicians. Dr. Frank Mayfield and Dr. John Tew, fine speakers themselves, insisted that the residents be understood. They needed assistance in using the

microphone, in phrasing, projection, articulation, timing, vocal variety, vocabulary and pronunciation. Most of them also needed improved writing skills as well as more knowledge of some technical areas.

"Small talk" and social situations, the FMGs confessed, made them extremely ill at ease. They didn't understand jokes and stories although they did develop their own kind of humor with one another. Some of them, of course, asked for information about schools for their children, licenses, and other kinds of information related to their living adjustments.

One of the most important functions I performed which was probably not recognized by the FMGs themselves but certainly by staff members and the educational director was that of counselor. My class offered the FMGs an opportunity to air gripes, to ask questions they may have hesitated to ask others and to resolve some conflicts between one another. Moreover, it was an opportunity to talk about their own countries and to make inquiry on sensitive subjects related to our culture in a setting that was no threat to them.

Let me point out that, because of the general fatigue of the FMGs and their different levels of proficiency, keeping the classes varied, lively and interesting was my greatest challenge. The classes were scheduled once a week at alternate hospitals at 4 p.m. which meant that each FMG attended only twice a month. If he was called for emergency surgery, it could be a month or longer between classes. This is hardly optimum exposure to instruction, nor was it possible to maintain much continuity. Classes often extended to an hour and a half,

even longer, and sometimes I worked with the group for an hour, then spent additional time with one individual who needed additional help. The atmosphere was kept informal and always began with some phatic communion.

The activities generally consisted of conversation, articulation and vocabulary exercises, reading of protocols (patient case histories) and articles interspersed with discussion, and simulation exercises. Depending on the needs of specific residents, some time was spent in writing protocols or papers. At the beginning of the class, particularly when a new FMG had entered the program, we conversed about their families, their work, their reactions to the city and such topics. This gave opportunity to discuss some cultural differences. Then we proceeded with specific activities that I had planned. Some time was devoted to exercises that gave practice in individual articulatory problems such as the l, v, r, th, f and mispronunciations, particularly those that might reflect incompetence to staff and knowledgeable patients, such as "dé̱termine" for "determine," "cóṉtributing," for "contríbuting," and "rā̱dius" for "radius." Some of the more conscientious FMGs took their list of troublesome words for reference and drill between classes, but aside from that, they did not do homework.

Next, each FMG was provided with copies of articles or editorials from current periodicals or the local newspaper which I judged to be pertinent to their interests and would help in social conversation. Popular articles related to medicine often led to discussion about

differences in cultural attitudes and myths about medicine. Other articles concerned the city, vacation spots, prominent physicians. To increase their technical vocabularies and knowledge, they read articles from the medical journals. The series published by Readers Digest to acquaint the public with physiology and anatomy ("I'm Joe's Heart," "I'm Jane's Breast," etc.) were particularly useful. Reading gave opportunity to correct and practice pronunciation (we kept the Garland Medical Dictionary at hand), articulation, rate, phrasing and vocal variety. To check content and comprehension, the participants were asked to paraphrase the content of the articles. An additional purpose in reading the medical literature and history was to provoke discussion which provided further opportunity for verbalizing ideas.

Simulation exercises provided an excellent means of practice in patient interviewing. Some rather humorous situations arose out of this method. For example, how do you ask a patient about his urination when he doesn't know the word? What does the patient mean when he is asked how he feels and he answers that he is "all pooped out?" Slang and regionalisms cause as much consternation for the FMGs as do some of their mispronunciations and terminology cause for the patients.

Several useful handbooks have been published to acquaint foreign physicians with medical and hospital organizations and practices in the U.S. as well as general conditions in this country. One chapter in The Handbook for Foreign Medical Graduates deals with the English language and defines slang expressions which can be extremely puzzling to foreigners: "Give me a ring," "Keep in touch," "Stick around,"

"on the dot," "gab," and "rat race."[34] This handbook also includes strictly personal problems and a section on the role of women. However, to my knowledge, this manual had not been made available to the FMGs and has come to my attention only recently. Another booklet, Multilingual Manual for Medical History Taking,[35] written by a physician who had encountered great language difficulties with a patient, includes 100 questions in six languages to be used in questioning and examining non-English speaking patients. Perhaps this is the book read by the resident who could ask the question, "Is your father living?" but could comprehend no response except "yes" or "no." These publications are useful in devising simulation exercises to help the FMG understand patients' descriptions of symptoms. An article with case histories and specific questions that would aid the physician in making a diagnosis was also very useful. It should be apparent from these examples that a variety of approaches can and should be used to instruct FMGs in language deficiencies as well as interpersonal skills and intercultural understanding. Certainly more and, perhaps, better methods can be improvised.

The strengths and weaknesses of this approach are readily apparent. Instruction was individualized to the extent that it was possible in a class which varied from one to five or six participants. More frequent meetings were needed for instruction and reinforcement; instruction should take place when time is unencumbered by other responsibilities; some kind of assigned exercises to be done on a regular basis would increase the rate of proficiency. Evaluation was difficult but I attempted to get feedback of the FMGs' progress from the FMGs and their

superior physicians regarding their delivery of protocols and general understandability. On occasion, I was asked to work with individuals on listening, clarity, and presentation of papers. I was accountable to the Institute to make assessments of progress, to report attendance, and to outline my objectives and procedures.

In summary, the need for training in communication skills and language proficiency for FMGs has been acknowledged in the journals, but relatively little attention appears to have been paid to this need. It seems, then, that we must sell our expertise, particularly in cities and states where the percentage of FMGs is high as in New York, Connecticut, Delaware, Illinois, Michigan, New Jersey, Ohio, Rhode Island and West Virginia. The Commission on FMGs, established by leading medical associations and activated in September, 1970, is one organization through which we might work. This Commission has as its purposes "to assist in the development of policies concerning the entry as well as education of foreign trained physicians." It also provides "a vehicle for orientation programs and specialized training sessions."[36] We can help initiate and develop cooperative programs as was done in Philadelphia or we can approach medical institutes with instructional programs. Where accuracy is so critical and where the need for trust and empathy is so important, we should find ways of meshing our professional expertise so that both professions can be more rewarding and productive.

"If," as Carl Rogers has said, "we are thoughtfully trying to understand our tasks as administrators, teachers, educational counselors,

therapists, then we are working on the problem which will determine the future of this planet. For it is not upon the physical sciences that the future will depend. It is upon us who are trying to understand and deal with interactions between human beings--who are trying to create helping relationships."[37]

Footnotes

[1] Carl R. Rogers, On Becoming a Person (Boston: Houghton-Mifflin, 1961), p. 54.

[2] "Special Report on the First Visa Qualifying Examination," Federation Bulletin, 65 (February 1978), 39.

[3] Laurence Scherr, "Coping with Intrusions by State and Federal Government Agencies," Federation Bulletin, 65 (March 1978), 77.

[4] Rosemary Stevens and Joan Vermeulen, Foreign Trained Physicians and American Medicine (U.S. Department of Health, Education and Welfare Public Health Service, National Institute of Health, June 1972), p. 11.

[5] JAMA, 2822.

[6] Aims C. McGuinnes, "ECFMG, United States Citizen Candidate Performance," Journal of the American Medical Association 214 (1970), 1685-86.

[7] Daniel Marien, Guide to Foreign Medical Schools (New York: Queens College Press/Institute of International Education, 1975).

[8] J. H. Haug and B. C. Martin, Foreign Medical Graduates in the United States, 1970. Chicago: American Medical Association, 1970, p. 5.; Samuel A. Overstreet, "Foreign Medical Trainees," Journal of Kentucky Medical Association, 68 (1970), 116.

[9] Stevens and Vermeulen, p. 31.

[10] Ibid., p. 22.

[11] Jacob L. Halberstam and Michael M. Dasco, "Foreign and United States Residents in University-Affiliated Teaching Hospitals: An Investigation of United States Graduate Medical Education," Bulletin of the New York Academy of Medicine, 42 (March, 1966), 204.

[12] Stevens and Vermeulen, p. xvi.

[13] Irene Butter, Foreign Medical Graduates: A Comparative Study of State Licensure Policies," U.S. Department of Health, Education and Welfare, Public Health Service, Health Services Research (1976), 1.

[14] Stevens and Vermeulen, p. 18.

[15] "Special Report," p. 39.

[16] Handbook for Foreign Medical Graduates. Philadelphia: Educational Commission for Foreign Medical Graduates (1976), 118-119.

[17] Ibid., p. 44.

[18] M. Dasco, L. Antler, and H. Rush, "The Foreign Medical Resident Training in the U.S.," Annals of Internal Medicine, 68 (1968), 1127.

[19] Harold Margulies, Lucille S. Bloch, Francis K. Cholko, "Random Survey of U.S. Hospitals with Approved Internships and Residencies: A Study of Professional Qualities of FMGs," Journal of Medical Education 43 (June 1968), 712.

[20] Butter, p. 8.

[21] Stephen S. Mick, "The Foreign Medical Graduate," Scientific American, 232 (February 1975), 21.

[22] Robert A. Saywell, Jr., James Studnicki, Judy A. Bean, and Robert L. Ludke, "A Performance Comparison: USMG-FMG Attending Physicians," American Journal of Public Health, 69 (January 1979), 62.

[23] Jacob L. Halberstam, Howard A. Rusk and Eugene J. Taylor, "Foreign Surgical Residents in University-Affiliated Hospitals: A Unique Case in United States Medical Education," Annals of Surgery, 171 (1970), 495.

[24] Robert C. Derbyshire, Medical Licensure and Discipline in the U.S. (Baltimore: The Johns Hopkins Press, 1969), 144.

[25] Brian Bird, Talking with Patients (Philadelphia: J. B. Lippincott Co., 1973), 1.

[26] Stevens and Vermeulen, p. 32.

[27] Alton I. Sutnick, "The Trainee from Abroad," Annals of Internal Medicine, 68 (1968), 1128.

[28] Alvan G. Foraker, Robert V. Joel, "A Positive Approach to the Foreign Pathology Resident," Archives of Pathology, 88 (1969), 453-54.

[29] Sutnick, pp. 1127-28.

[30] Dean C. Barnlund, "Toward a Meaning-Centered Philosophy of Communication," Basic Readings in Interpersonal Communication, eds. Kim Griffin and Bobby R. Patton (New York: Harper and Row, Publishers, 1971), 45.

[31] Dean C. Barnlund, "A Transactional Model of Communication," Basic Readings in Communication Theory, 2nd. ed., ed. C. David Mortensen (New York: Harper and Row, Publishers, 1979), 55.

[32] Edward T. Hall, "Adumbration as a Feature of Intercultural Communication," Basic Readings in Communication Theory, p. 427.

[33] Comments made by Dean C. Barnlund at the national convention of the Speech Communication Association, Washington, D.C., 1977, at which he delivered a paper, "Communication and Health Care: Research Perspectives," and responded to the panel of papers in the Dimension series.

[34] Handbook for Foreign Medical Graduates, pp. 62-63.

[35] Louis R. M. Del Guerico, Multilingual Manual for Medical History Taking (Boston: Little, Brown and Co., 1972).

[36] Stevens and Vermeulen, p. 73.

[37] Rogers, pp. 56-57.